NEW YORK STATE DEPARTMENT OF HEALTH
OFFICE OF QUALITY AND PATIENT SAFETY

EXTERNAL QUALITY REVIEW TECHNICAL REPORT FOR:

HUDSON HEALTH PLAN, INC.

Reporting Year 2015

Published April 2017

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Acronyms Used in This Report

ALOS: *Average Length of Stay*
AO: *Area Office*

CHP: *Child Health Plus*
COM (C): *Commercial*

DBA: *Doing Business As*
DSS: *Data Submission System*

EQR: *External Quality Review*
EQRO: *External Quality Review Organization*

F/A: *Failed Audit*
FAR: *Final Audit Report*
FFS: *Fee For Service*
FHP: *Family Health Plus*
FTE: *Full Time Equivalent*

HCS: *Health Commerce System*
HEDIS: *Health Effectiveness Data and Information Set*
HIE: *Health Information Exchange*
HIT: *Health Information Technology*
HMO: *Health Maintenance Organization*
HPN: *Health Provider Network*

MCO: *Managed Care Organization*
MED (M): *Medicaid*
MMC: *Medicaid Managed Care*
MMCOR: *Medicaid Managed Care Operating Report*

N: *Denominator*
N/A: *Not Available*
NCQA: *National Committee for Quality Assurance*
NP: *Not Provided*
NR: *Not Reported*
NV: *Not Valid*
NYC: *New York City*
NYCRR: *New York Code Rules and Regulations*
NYSDOH: *New York State Department of Health*

OB/GYN: *Obstetrician/Gynecologist*
OPMC: *Office of Professional Medical Conduct*
OP: *Optimal Practitioner Contact*
OQPS: *Office of Quality and Patient Safety*

PCP: *Primary Care Practitioner/Provider*
PIP: *Performance Improvement Project*
PNDS: *Provider Network Data System*
POC: *Plan of Corrective Action*
PMPY: *Per Member Per Year*
PTMY: *Per Thousand Member Years*
PHSP: *Prepaid Health Services Plans*
PQI: *Prevention Quality Indicator*

Q1: *First Quarter (Jan. – March)*
Q2: *Second Quarter (Apr. – June)*
Q3: *Third Quarter (July – Sept.)*
Q4: *Fourth Quarter (Oct. – Dec.)*
QARR: *Quality Assurance Reporting Requirements*

R: *Rotated*
ROS: *Rest of State*
RY: *Reporting Year*

SN: *Safety Net*
SOD: *Statement of Deficiency*
SS: *Small Sample (Less than 30)*
SSI: *Supplemental Security Income*
SWA: *Statewide Average*

TANF: *Temporary Aid to Needy Families*
TR: *Technical Report*

UR: *Utilization Review*

I. About This Report

New York State (NYS) is dedicated to providing and maintaining the highest quality of care for enrollees in managed health care plans. The New York State Department of Health's (NYSDOH) Office of Quality and Patient Safety (OQPS) employs an ongoing strategy to improve the quality of care provided to plan enrollees, to ensure the accountability of these plans, and to maintain the continuity of care to the public.

The technical reports are individualized reports on the Managed Care Organizations (MCOs) certified to provide Medicaid coverage in NYS. In accordance with federal requirements, these reports summarize the results of the 2015 External Quality Review (EQR) to evaluate access to, timeliness of, and quality of care provided to NYS Medicaid beneficiaries. Mandatory EQR-related activities (as per Federal Regulation 42 CFR §438.358) reported include validation of performance improvement projects (PIPs), validation of MCO-reported and NYSDOH-calculated performance measures, and review for MCO compliance with NYSDOH structure and operation standards. Optional EQR-related activities (as per Federal Regulation 42 CFR §438.358) reported include administration of a consumer survey of quality of care (CAHPS®) by an NCQA-certified survey vendor and technical assistance by the NYS EQRO to MCOs regarding PIPs and reporting performance measures. Other data incorporated to provide additional background on the MCOs include the following: health plan corporate structure, enrollment data, provider network information, encounter data summaries, PQI/compliance/ satisfaction/quality points and incentive, deficiencies and appeals summaries, and financial data.

These reports are organized into the following domains: Corporate Profile, Enrollment and Provider Network, Utilization, Quality Indicators, Health Information Technology, Deficiencies and Appeals, and Financial Data. Although the reports focus primarily on Medicaid data, selected sections of these reports also include data from the MCOs' Child Health Plus (CHP) and Commercial product lines. For some measures, including QARR 2016 (MY 2015) aggregate rates are used, which represent the population of various product lines. These measures are noted as such. Additionally, when available and appropriate, the MCOs' data are compared with statewide benchmarks. Unless otherwise noted, when benchmarks are utilized for rates other than HEDIS®/QARR or CAHPS®, comparative statements are based on differences determined by standard deviations: a difference of one standard deviation is used to determine rates that are higher or lower than the statewide average.

Section IX provides an assessment of the MCO's strengths and opportunities for improvement in the areas of accessibility, timeliness, and quality of services. For areas in which the MCO has opportunities for improvement, recommendations for improving the quality of the MCO's health care services are provided. To achieve full compliance with federal regulations, this section also includes an assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report. The MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve. The response by the MCO is appended to this section of the report.

In an effort to provide the most consistent presentation of this varied information, the technical report is prepared based on data for the most current calendar year available. Where trending is desirable, data for prior calendar years may also be included. This report includes data for Reporting Year 2015.

II. MCO Corporate Profile

Hudson Health Plan, Inc. (Hudson) is a regional, not-for-profit prepaid health services plan (PHSP) that services Medicaid (MCD) and Child Health Plus (CHP) populations. On October 31, 2013, the Department approved the acquisition of Hudson Health Plan, Inc. by MVP Health Plan, Inc. (MVP). On January 1, 2016, the Medicaid and Child Health Plus populations of Hudson Health Plan, Inc. migrated to MVP. The following report presents plan-specific information for the Medicaid line of business and selected information for the CHP product line.

- Plan ID: 2040287
- DOH Area Office: MARO
- Corporate Status: PHSP
- Tax Status: Not-for-profit
- Medicaid Managed Care Start Date: June 22, 1987
- Product Lines: Medicaid (MCD) and Child Health Plus (CHP)
- Contact Information: 303 South Broadway, Suite 321
  Tarrytown, NY 10591
  (914) 631-1611
- NCQA Accreditation Status as of 08/31/14: Did not apply
- Medicaid Dental Benefit Status: Mandatory Benefit

Participating Counties and Products

Dutchess:	MCD	CHP	**Orange:**	MCD	CHP	**Rockland:**	MCD	CHP
Sullivan:	MCD	CHP	**Ulster:**	MCD	CHP	**Westchester:**	MCD	CHP

III. Enrollment and Provider Network

ENROLLMENT

Table 1 displays enrollment for the MCO's Medicaid product line for 2013, 2014, and 2015, as well as the percent change from the previous year. Enrollment has increased from 2014 to 2015 by a rate of 6.5%. **Table 2** presents enrollment from other product lines carried by the MCO. **Figure 1** trends enrollment for all product lines.

Table 1: Medicaid Enrollment—2013-2015

	2013	2014	2015
Number of Members	98,624	143,014	152,266
% Change From Previous Year		45.0%	6.5%

Data Source: MEDS II

Table 2: Enrollment: Other Product Lines—2013-2015

	2013	2014	2015
FHP[1]	11,596		
CHP	14,897	13,382	10,805

[1] In RY 2014, the MCO discontinued its Family Health Plus product line.

Figure 1: Enrollment Trends—All Product Lines

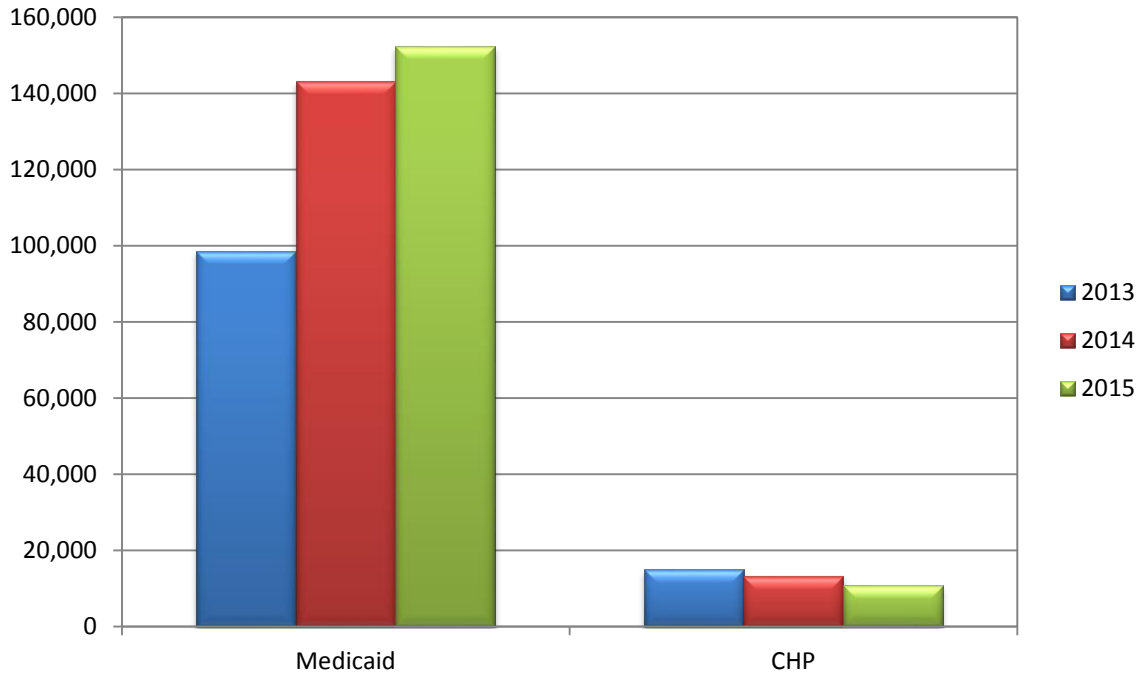
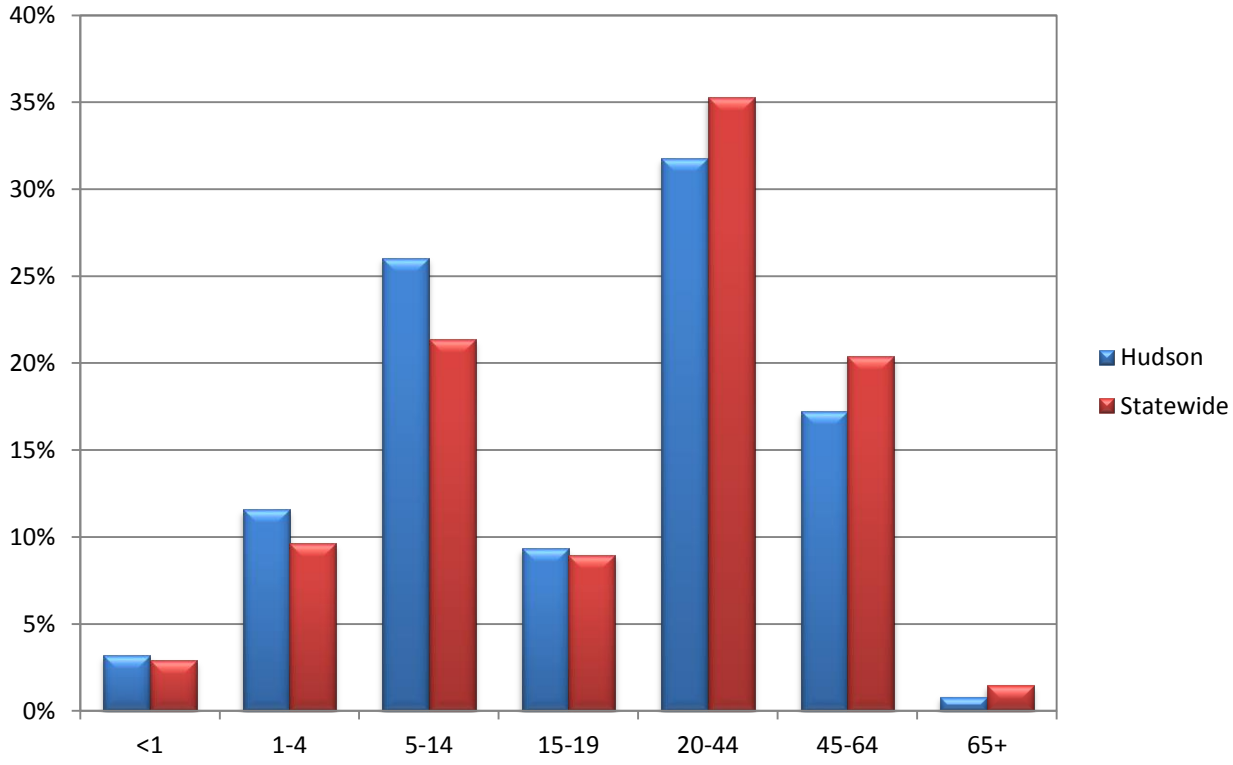


Table 3 and **Figure 2** display a breakdown of the MCO's enrollment by age and gender as of December 31, 2015, for the Medicaid product line. The table also indicates whether the MCO's rate is above (indicated by ▲) or below (indicated by ▼) the statewide average.

Table 3: Medicaid Membership Age and Gender Distribution—December 2015

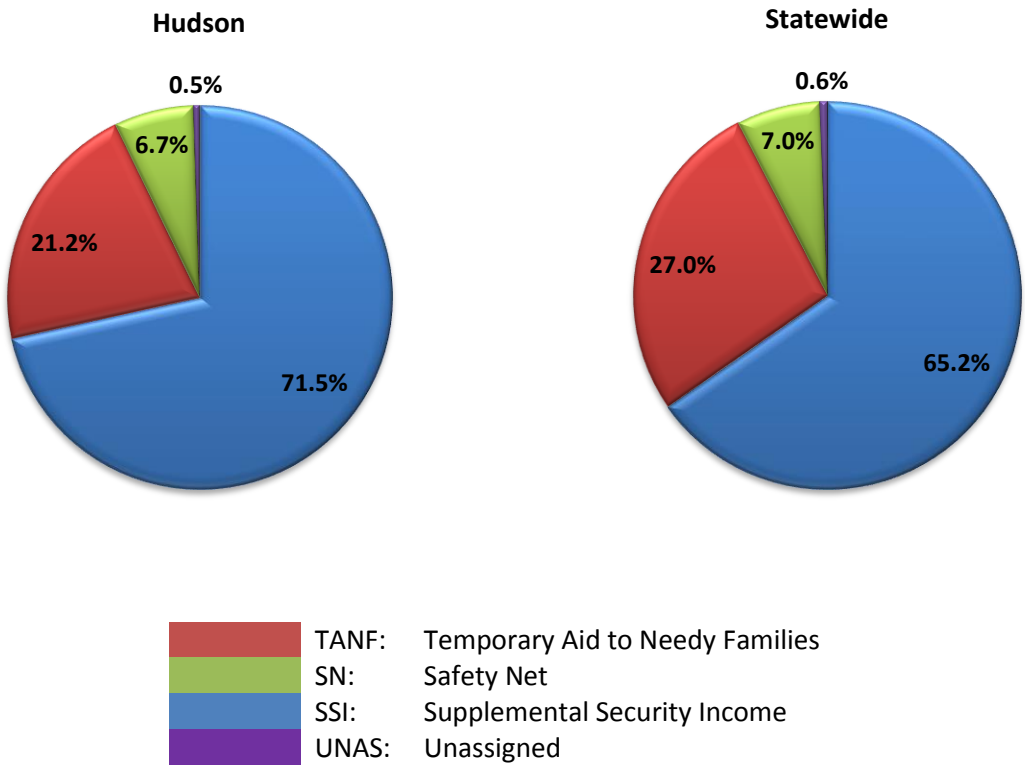
Age in Years	Male	Female	Total	MCO Distribution	Statewide
Under 1	2,489	2,362	4,851	3.2%	2.9%
1-4	9,004	8,635	17,639	11.6% ▲	9.6%
5-14	20,319	19,366	39,685	26.1% ▲	21.4%
15-19	7,074	7,168	14,242	9.4%	9.0%
20-44	17,885	30,504	48,389	31.8% ▼	35.3%
45-64	11,297	14,934	26,231	17.2% ▼	20.4%
65 and Over	411	818	1,229	0.8%	1.5%
Total	**68,479**	**83,787**	**152,266**		
Under 20	38,886	37,531	76,417	50.2% ▲	42.9%
Females 15-64		52,606		34.5% ▼	36.5%

Figure 2: Medicaid Enrollees by Age—December 2015



A breakdown of MCO membership by aid category, as reported by the NYSDOH for December 31, 2015, is shown in **Figure 3**.

Figure 3: Medicaid Enrollees by Aid Category—December 2015



PROVIDER NETWORK

Table 4 shows the percentages of various provider types in the MCO's Medicaid product line for the fourth quarter of 2015 in comparison to the statewide rates. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicate by ▼.

Table 4: Medicaid Providers by Specialty—2015 (4th Quarter)

Specialty	Number	% of Total MCO Panel	% Statewide
Primary Care Providers	1,001	18.3%	20.0%
Pediatrics	349	6.4% ▲	4.7%
Family Practice	223	4.1%	4.0%
Internal Medicine	299	5.5% ▼	8.3%
Other PCPs	130	2.4%	2.9%
OB/GYN Specialty[1]	260	4.8%	4.7%
Behavioral Health	1,384	25.4%	20.0%
Other Specialties	2,599	47.6%	45.8%
Non-PCP Nurse Practitioners	92	1.7%	7.7%
Dentistry	121	2.2%	1.8%
Total	**5,457**		

Data Source: HCS

[1] Includes OB/GYN specialists, certified nurse midwives, and OB/GYN nurse practitioners.

Table 5 displays the ratio of enrollees to providers, as well as the number of Full Time Equivalents (FTEs), and the ratio of enrollees to FTEs for the fourth quarter of 2015. Statewide data are also included. For this table, rates above the 90th percentile are indicated by ▲, while rates below the 10th percentile are indicated by ▼. Note that a higher percentile indicates fewer providers per enrollee.

Table 5: Ratio of Enrollees to Medicaid Providers—2015 (4th Quarter)

Specialty Type	Hudson			Statewide		
	Ratio of Enrollees to Providers	Total Number of FTEs	Ratio of Enrollees to FTEs	Median Ratio of Enrollees to Providers[1]	Total Number of FTEs	Median Ratio of Enrollees to FTEs
Medicaid						
Primary Care Providers	152:1	779	196:1 ▲	100:1	42,807	104:1
Pediatrics (Under age 20)	219:1			150:1		
OB/GYN (Females age 15-64)	33:1 ▼			110:1		
Behavioral Health	110:1			89:1		

Data Source: Derived ratios calculated from MEDS II enrollment data and HCS provider data.

[1] The statewide median was used for this table, as opposed to an average, to control for substantial variability due to outliers.

The number of Medicaid PCPs with an "Open Panel" is presented in **Table 6** for the fourth quarters of 2013 through 2015. Panels are considered "open" if a provider has less than 1,500 Medicaid members. For this table, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicated by ▼.

Table 6: Medicaid PCPs with an Open Panel—2013-2015 (4th Quarter)

	2013			2014			2015		
	Hudson		Statewide	Hudson		Statewide	Hudson		Statewide
	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers	Number	% of Providers	% of Providers
Medicaid									
Providers with Open Panel	791	89.7%	88.8%	853	91.5%	87.6%	817	87.1%	86.1%

Data Source: HCS

Table 7 displays HEDIS®/QARR *Board Certification* rates for 2013 through 2015 of providers in the MCO's network in comparison to the statewide averages. The table also indicates whether the MCO's rate was above (indicated by ▲) or below (indicated by ▼) the statewide average.

Table 7: HEDIS®/QARR Board Certification Rates—2013-2015

Provider Type	2013		2014		2015	
	Hudson	Statewide Average	Hudson	Statewide Average	Hudson	Statewide Average
			Medicaid/CHP			
Family Medicine	81%	78%	79%	77%	80%	77%
Internal Medicine	77%	78%	77%	77%	77%	76%
Pediatricians	78%	80%	86%	80%	87% ▲	79%
OB/GYN	74%	78%	78%	75%	79%	76%
Geriatricians	SS	69%	SS	64%	SS	63%
Other Physician Specialists	82% ▲	78%	83% ▲	76%	83% ▲	76%

SS: Sample size too small to report (less than 30 providers), but included in the statewide average.

PRIMARY CARE AND OB/GYN ACCESS AND AVAILABILITY SURVEY—2015

On behalf of the NYSDOH's Division of Health Plan Contracting and Oversight, the NYS EQRO conducts the Medicaid Managed Care Access and Availability Survey to assess the compliance of network providers in NYS MCOs with appointment timeframe requirements as per the NYS Medicaid/Family Health Plus Managed Care Contract. The survey evaluates the availability of routine and non-urgent "sick" office hour appointments with primary care physicians, including OB/GYNs, as well as the availability of after hours access.

The timeliness standard for routine office hour appointments with PCPs and OB/GYNs is within 28 days of the enrollee's request, while non-urgent "sick" office hour appointments with PCPs and OB/GYNs must be scheduled within 72 hours (excluding weekends and holidays) as clinically indicated. Prenatal appointments with OB/GYN providers within the 2nd trimester must be given within 14 days, while 3rd trimester appointments must be given within 7 days. After hours access is considered compliant if a "live voice" representing the named provider is reached or if the named provider's beeper number is reached.

Note: At the time of publication of this report, the Access and Availability Survey was in progress. The results of the 2016 Access and Availability Survey will be published in the RY 2016 Technical Reports.

IV. Utilization

This section of the report explores utilization of the MCO's services by examining encounter and health screening data, as well as QARR Use of Services rates.

ENCOUNTER DATA

Table 8 displays selected Medicaid encounter data for 2013 through 2015. The MCO's rates for these periods are also compared to the statewide averages. For this table, rates above the statewide average are indicated by ▲, while rates below the statewide average are indicate by ▼.

Table 8: Medicaid Encounter Data—2013-2015

	Encounters (PMPY)					
	2013		2014		2015	
	Hudson	Statewide Average	Hudson	Statewide Average	Hudson	Statewide Average
PCPs and OB/GYNs	4.26	4.45	4.10	4.36	3.03 ▼	4.12
Specialty	2.71 ▲	1.90	2.71 ▲	1.94	2.23	1.92
Emergency Room	0.70	0.60	0.95 ▼	2.11	0.55	0.54
Inpatient Admissions	0.15	0.14	0.14	0.15	0.22 ▲	0.14
Dental	1.20	1.00	1.19	1.03	1.14	0.99

Data Source: MEDS II
PMPY: Per Member Per Year

HEALTH SCREENINGS

In accordance with 13.6(a)(ii) of the Medicaid Managed Care and Family Health Plus Model Contract, MCOs must make reasonable efforts to contact new enrollees within 30 days of enrollment either in person, by telephone, or by mail, and conduct a brief health screening to assess special health care needs (e.g., prenatal care or behavioral health services), as well as language and communication needs. MCOs are required to submit a quarterly report to the NYSDOH showing the percentage of new enrollees for which the MCO was able to complete health screenings. **Table 9** summarizes the percentage of Medicaid enrollees receiving health screenings within 30 days of enrollment from 2013 through 2015, in addition to displaying the statewide averages for these years. For this table, rates above the statewide average are indicated by ▲, and rates below the statewide average are indicated by ▼.

Table 9: Health Screenings—2013-2015

	2013		2014		2015	
	Hudson	SWA	Hudson	SWA	Hudson	SWA
			Medicaid			
Enrollee Health Screenings	36.6%	25.3%	28.3% ▲	15.1%	19.8%	14.9%

QARR USE OF SERVICES MEASURES

For this domain of measures, performance is assessed by indicating whether the MCO's rates reached the 90th or 10th percentiles. **Table 10** lists the Use of Services rates for the selected product lines for 2013 through 2015. The table displays whether the MCO's rate was higher than 90% of all rates for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of all rates for that measure (indicated by ▼).

Table 10: QARR Use of Services—2013-2015

	Medicaid/CHP			
Measure	**2013**	**2014**	**2015**	**2015 Statewide Average**
		Outpatient Utilization (PTMY)		
Visits	5,485	4,541	5.369	5,398
ER Visits	642	588	627	554
		Inpatient ALOS		
Medicine	4.2	4.9 ▲	3.7	4.1
Surgery	7.4	6.3	4.9 ▼	6.2
Maternity	2.9	2.9	2.7	2.8
Total	4.3	4.5	3.6 ▼	4.1
		Inpatient Utilization (PTMY)		
Medicine Cases	35	33	42	36
Surgery Cases	17	14	16	15
Maternity Cases	54 ▲	43	42 ▲	32
Total Cases	86	77	86	75

PTMY: Per Thousand Member Years

ALOS: Average Length of Stay. These rates are measured in days.

V. Quality Indicators

To measure the quality of care provided by the MCOs, the State prepares and reviews a number of reports on a variety of quality indicators. This section is a summary of findings from these reports, including HEDIS®/QARR 2016 audit findings, as well as results of quality improvement studies, enrollee surveys, and MCO Performance Improvement Projects (PIPs).

VALIDATION OF PERFORMANCE MEASURES

Performance measures are reported and validated using several methodologies. MCOs submitted member- and provider-level data for several measures to the NYSDOH. The NYS EQRO audited all member- and provider-level data for internal consistency. Several performance measures are calculated by the NYSDOH, with source code validated by the NYS EQRO. Finally, MCOs report a subset of HEDIS® measures to the NYSDOH annually, along with several NYS-specific measures. MCO-reported performance measures were validated as per HEDIS® 2016 Compliance Audit™ specifications developed by the National Committee for Quality Assurance (NCQA).

Since measurement year (MY) 2013, the methodology for reporting performance rates was modified. Previously, Medicaid and Child Health Plus (CHP) were reported separately; however, for QARR 2016 (MY 2015), rates for these populations were combined, following HEDIS® methodology (summing numerators and denominators from each population). Trend analysis has been applied over the time period, as the effect of combining the CHP and Medicaid populations was determined to be negligible through an analysis of historical QARR data.

The results of each MCO's HEDIS® Compliance Audit™ are summarized in its Final Audit Report (FAR).

SUMMARY OF HEDIS® 2016 INFORMATION SYSTEM AUDIT™

As part of the HEDIS® 2016 Compliance Audit™, auditors assessed the MCO's compliance with NCQA standards in the six designated information system categories, as follows:

1. Sound Coding Methods for Medical Data
2. Data Capture, Transfer, and Entry—Medical Data
3. Data Capture, Transfer, and Entry—Membership Data
4. Data Capture, Transfer, and Entry—Practitioner Data
5. Data Integration Required to Meet the Demands of Accurate HEDIS® Reporting
6. Control Procedures that Support HEDIS® Reporting and Integrity

In addition, two HEDIS®-related documentation categories were assessed:

1. Documentation
2. Outsourced or Delegated HEDIS® Reporting Functions

The NYS EQRO provided technical assistance to MCOs throughout the performance measure reporting process in the following forms: 1) introductory and technical workshops prior to the audit, 2) readiness reviews for new MCOs, 3) serving as a liaison between the MCOs and NCQA to clarify questions regarding measure specifications, 4) preparation of and technical support for the Data Submission System (DSS) used to submit data to the NYSDOH, and 5) clarifications to MCO questions regarding the submission of member- and provider-level data, as well as general questions regarding the audit process.

The HEDIS® Final Audit Report (FAR) prepared for Hudson indicated that the MCO had no significant issues in any area related to reporting. The MCO demonstrated compliance with all areas of Information Systems and all areas of measure determination required for successful HEDIS®/QARR reporting.

The MCO used NCQA-certified software to produce HEDIS® measures. Supplemental databases used to capture additional data were validated and determined to be HEDIS®-compliant by the auditors. No issues were identified with the transfer or mapping of the data elements for reporting.

Hudson passed Medical Record Review for the four measures validated, as well as for Exclusions. Hudson was able to report all measures for the Medicaid product line.

Table 11 displays QARR performance rates for Measurement Years 2013, 2014, and 2015, as well as the statewide averages (SWAs). The table indicates whether the MCO's rate was statistically better than the SWA (indicated by ▲) or whether the MCO's rate was statistically worse than the SWA (indicated by ▼).

Table Notes for Table 11	
R:	Rotated measure.
NR:	Not reported.
NP:	Dental benefit not provided.
FY:	First-Year Measure, MCO-specific rates not reported.
SS:	Sample size too small to report (less than 30 members) but included in the statewide average.

Table 11: QARR MCO Performance Rates—2013-2015

Measure	Medicaid/CHP			
	2013	2014	2015	2015 SWA
Follow-up Care for Children on ADHD Meds—Continue	68	71	74	**67**
Follow-up Care for Children on ADHD Meds—Initial	56	58	58	**58**
Adolescents—Alcohol and Other Drug Use	66	R	75 ▲	**68**
Adolescents—Depression	59	R	66 ▲	**60**
Adolescents—Sexual Activity	62	R	68	**65**
Adolescents—Tobacco Use	69	R	81 ▲	**74**
Adolescent Immunization—Combo	77 ▲	R	78	**74**
Adolescent Immunization—HPV	28	29	27	**31**
Adult BMI Assessment	91 ▲	R	87	**90**
Flu Shot for Adults (Ages 18-64)	42	R	35 ▼	**40**
Advising Smokers to Quit	78	R	78	**80**
Follow-up After Hospitalization for Mental Illness—30 Days	83 ▲	83 ▲	78	**79**
Follow-up After Hospitalization for Mental Illness—7 Days	67	67	61	**65**
Antidepressant Medication Management—Continue	32	33	36	**37**
Antidepressant Medication Management—Acute Phase	49	52	51	**52**
Drug Therapy for Rheumatoid Arthritis	69 ▼	69 ▼	75	**81**
Asthma Medication Ratio (Ages 19-64)	56	57	56	**54**
Asthma Medication Ratio (Ages 5-18)	73	70 ▲	68 ▲	**62**
Use of Imaging Studies for Low Back Pain	71 ▼	71 ▼	68 ▼	**76**
Persistence of Beta-Blocker Treatment After a Heart Attack	SS	79	89	**86**
Avoidance of Antibiotics for Adults with Acute Bronchitis	23	24	26	**30**
Chlamydia Screening (Ages 16-24)	71	67 ▼	70 ▼	**73**
Colon Cancer Screening	55	R	50 ▼	**61**
Dental Visit (Ages 19-21)	44	43	45	**44**
Annual Dental Visits (Ages 2-18)	68 ▲	66 ▲	69 ▲	**60**
Diabetes BP Controlled (<140/90 mm Hg)	77 ▲	R	73 ▲	**68**
Diabetes HbA1c below 8%	62 ▲	R	56	**57**
Diabetes Eye Exam	62	R	65	**63**
Diabetes Nephropathy Monitor	80	R	91	**93**
Diabetes HbA1c Test	90	R	90	**91**

Table 11: QARR MCO Performance Rates—2013-2015 (continued)

Measure	Medicaid/CHP			
	2013	2014	2015	2015 SWA
HIV—Engaged in Care	91 ▲	86	72 ▼	**82**
HIV—Syphilis Screening	74	71	59 ▼	**74**
HIV—Viral Load Monitoring	78 ▲	68	66	**71**
Childhood Immunization—Combo 3	78 ▲	R	76	**75**
Lead Testing	86 ▼	R	88	**87**
Breast Cancer Screening	70	67 ▼	71	**71**
Smoking Cessation Medications	58	R	55	**59**
Medical Management for People with Asthma 50% (Ages 19-64)	60 ▼	61 ▼	61 ▼	**68**
Medical Management for People with Asthma 50% (Ages 5-18)	45 ▼	43 ▼	48 ▼	**53**
Smoking Cessation Strategies	48	R	48	**51**
Monitor Patients on Persistent Medications—Combined	91	89 ▼	90 ▼	**92**
Pharmacotherapy Management for COPD—Bronchodilator	88	90	87	**88**
Pharmacotherapy Management for COPD—Corticosteroid	77	74	77	**75**
Testing for Pharyngitis	86	90 ▲	89	**88**
Diabetes Monitoring for Schizophrenia	81	73	72	**80**
Diabetes Screen for Schizophrenia or Bipolar Disorder on Antipsychotic Meds	86	82	83	**82**
Antipsychotic Meds for Schizophrenia	63	62	59	**61**
Spirometry Testing for COPD	40 ▼	45 ▼	45 ▼	**56**
Treatment for Upper Respiratory Infection	93	94 ▲	95	**94**
Well-Child Visits—First 15 Months	71 ▲	68	65	**65**
Well-Child Visits—3 to 6 Years	86 ▲	76 ▼	81 ▼	**84**
Well-Care Visits for Adolescents	64	58 ▼	61 ▼	**65**
Children BMI	88 ▲	R	86 ▲	**77**
Children Counseling for Nutrition	82 ▲	R	83 ▲	**80**
Children Counseling for Physical Activity	79 ▲	R	77 ▲	**72**

QARR ACCESS TO/AVAILABILITY OF CARE MEASURES

The QARR Access to/Availability of Care measures examine the percentages of children and adults who access certain services, including PCPs or preventive services, prenatal and postpartum care, and dental services for selected product lines. **Table 12** displays the Access to/Availability of Care measures for Measurement Years 2013 through 2015. The table indicates whether the MCO's rate was higher than 90% of all MCOs for that measure (indicated by ▲) or whether the MCO's rate was lower than 90% of MCOs for that measure (indicated by ▼).

Table 12: QARR Access to/Availability of Care Measures—2013-2015

Measure	Medicaid/CHP			
	2013	2014	2015	2015 SWA
Children and Adolescents' Access to PCPs (CAP)				
12-24 Months	98% ▲	98% ▲	95%	95%
25 Months-6 Years	96% ▲	93% ▼	92% ▼	94%
7-11 Years	97% ▲	96%	96% ▼	97%
12-19 Years	95% ▲	94%	94% ▼	94%
Adults' Access to Preventive/Ambulatory Services (AAP)				
20-44 Years	86% ▲	83% ▼	84% ▲	83%
45-64 Years	91%	89% ▼	91%	90%
65+ Years	91%	90%	89%	90%
Access to Other Services				
Timeliness of Prenatal Care	R	93% ▲	92% ▲	88%
Postpartum Care	R	74% ▲	75% ▲	70%
Annual Dental Visit[1]	66% ▲	64% ▲	68% ▲	59%

R: Rotated measure

[1] For the Annual Dental Visit measure, the Medicaid age group is 2-21 years, while the Child Health Plus age group is 2-18 years.

NYSDOH-CALCULATED QARR PRENATAL CARE MEASURES

Certain QARR prenatal care measures are calculated by the NYSDOH using birth data submitted by the MCOs, as well as from NYSDOH's Vital Statistics Birth File. Since some health events, such as low birth weight births and cesarean deliveries, do not occur randomly across all MCOs, risk adjustment is used to remove or reduce the effects of confounding factors that may influence an MCO's rate. **Table 13** presents prenatal care rates calculated by the NYSDOH for QARR 2012 through 2014. In addition, the table indicates if the MCO's rate was significantly better than the average (indicated by ▲) or whether the MCO's rate was significantly worse than the average (indicated by ▼).

Table 13: QARR Prenatal Care Measures—2012-2014

Measure	2012		2013		2014	
	Hudson	NYS/ROS Average	Hudson	NYS/ROS Average	Hudson	NYS/ROS Average
				ROS		
Risk-Adjusted Low Birth Weight[1]	7%	7%	7%	7%	8%	7%
Prenatal Care in the First Trimester	69%	71%	73%	72%	72%	74%
Risk-Adjusted Primary Cesarean Delivery[1]	16%	15%	18%	15%	16%	13%
Vaginal Birth After Cesarean	7%	11%	8%	12%	10%	13%

[1] A low rate is desirable for this measure.

ROS: Rest of State

MEMBER SATISFACTION

In 2015, the CAHPS® survey for Medicaid enrollees was conducted on behalf of the NYSDOH by an NCQA-certified survey vendor. **Table 14** displays the question category, the MCO's rates, and statewide averages for Measurement Years 2011, 2013, and 2015. The table also indicates whether the MCO's rate was significantly better than the statewide average (SWA) (indicated by ▲) or whether the MCO's rate was significantly worse than the SWA (indicated by ▼).

Table 14: CAHPS®—2011, 2013, and 2015

Measure	2011		2013		2015	
	Hudson	Statewide Average	Hudson	Statewide Average	Hudson	Statewide Average
Medicaid						
Flu Shots for Adults Ages 18-64[1]			42	44	35	40
Advising Smokers to Quit	74	78	78	78	78	80
Getting Care Needed[2]	77	75	84 ▲	78	84 ▲	79
Satisfaction with Provider Communication[2]	88	87	91	89	93 ▲	91
Coordination of Care[2]	71	68	80	78	81	80
Customer Service[2]	89 ▲	81	91 ▲	82	88	84
Collaborative Decision Making[2]	58	58	56 ▲	48	76	79
Rating of Healthcare	72 ▲	67	75	71	78	75
Rating of Health Plan—High Users	83 ▲	73	86 ▲	77	83 ▲	77
Getting Care Quickly[2]	79	76	84 ▲	78	83	80
Rating of Counseling/Treatment	66	59	64	61	67	64
Overall Rating of Health Plan	81 ▲	71	82 ▲	76	79	76
Rating of Personal Doctor[2]	76	73	81	78	83	80
Rating of Specialist	74	69	80	76	85 ▲	80
Getting Needed Counseling/Treatment	80 ▲	71	79	70	77	74
Recommend Plan to Family/Friends	94 ▲	91	97 ▲	92	96 ▲	93
Wellness Discussion	59	55	71	71	68	68

[1] Prior to 2013, this measure was reported for adults age 50-64 years.

[2] These indicators are composite measures.

QUALITY PERFORMANCE MATRIX ANALYSIS—2015 MEASUREMENT YEAR

Table 15 displays the Quality Performance Matrix, which predominantly summarizes Effectiveness of Care measures, though it also contains select Use of Services and Access to/Availability of Care measures reported annually in the New York State Managed Care Plan Performance Report. Fifty-eight measures were selected for the 2015 Measurement Year (MY) Quality Performance Matrix, which included combined measures for the Medicaid and CHP product lines. The matrix diagrams the MCO's performance in relation to its previous year's quality rates and also compares its rates to those of other Medicaid Managed Care Organizations through a percentile ranking.

For the MY 2012 Quality Performance Matrix, the NYSDOH made modifications in order to focus on those measures in need of the most improvement statewide. For previous measurement years, the cell category (A-F) was determined by the year-over-year trend of the measure (vertical axis) and by any significant difference from the statewide average (horizontal axis). For the 2012 MY, the matrix was reformatted to maintain the year-over-year evaluation on the vertical axis, but to evaluate the MCO's performance based on a percentile ranking on the horizontal axis. The new percentile ranking was partitioned into three categories: 0-49th percentile, 50th-89th percentile, and 90th-100th percentile. The 2012 matrix included only those measures for which the 2011 Medicaid statewide average was less than a predetermined benchmark; however, for MY 2015, additional measures were included to provide MCOs with a broader overview of quality performance, and further assist MCOs in identifying and prioritizing quality improvement.

With the issuance of the 2008 MY Matrix, the NYSDOH modified its MCO requirements for follow-up action. In previous years, MCOs were required to develop root cause analyses and plans of action for all measures reported in the D and F categories of the matrix. Starting with the 2008 MY Matrix, MCOs were required to follow-up on no more than three measures from the D and F categories of the matrix. However, if an MCO had more than three measures reported in the F category, the MCO was required to submit root causes analyses and plans of action on all measures reported in the F category. For the MY 2015 Matrix, this requirement was modified, requiring the MCO to submit a maximum of three root cause analyses and plans of action, regardless of the number of measures reported in the F category. Beginning with MY 2008, if an MCO has fewer than three measures reported in the F category, the remaining measures must be selected from the D category for a total of three measures. If the MCO has no measures in the D and F categories, the MCO is not required to follow up.

Table 15: Quality Performance Matrix—2015 Measurement Year

Trend*	Percentile Ranking: 0 to 49%	50% to 89%	90 to 100%
▲	**C**	**B** Persistence of Beta-Blocker Treatment after a Heart Attack	**A**
No Change	**D** Adherence to Antipsychotic Medications for Individuals with Schizophrenia Advising Smokers to Quit Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors/ARBs Annual Monitoring for Patients on Persistent Medications—Diuretics Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis Cervical Cancer Screening Childhood Immunization Status (Combo 3) Chlamydia Screening (Ages 16-20) Chlamydia Screening (Ages 21-24) Colon Cancer Screening Controlling High Blood Pressure Diabetes Monitoring for Diabetes and Schizophrenia Discussing Smoking Cessation Strategies Follow-Up After Hospitalization for Mental Illness—7 Days Medical Mgmt for People with Asthma 50% (Ages 5-64) Medical Mgmt for People with Asthma 75% (Ages 5-64) Tobacco Cessation—Medication Discussion Use of Imaging Studies for Low Back Pain Use of Spirometry Testing in the Assessment of COPD Well Care Visits—3rd, 4th, 5th, & 6th Year of Life	**C** Adolescent Immunization—Combo Adolescent Immunization—HPV Adult BMI Assessment Annual Monitoring for Patients on Persistent Medications—Digoxin Antidepressant Medication Management—Acute Phase Antidepressant Medication Management—Continuation Phase Appropriate Testing for Pharyngitis Breast Cancer Screening Counseling for Nutrition Counseling for Physical Activity Follow-Up Care for Children Prescribed ADHD Medication—Continuation Phase Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase Managing Diabetes Outcomes—HbA1c Control (<8.0%) Monitoring Diabetes—Received All Tests Weight Assessment—BMI Percentile	**B** Annual Dental Visits (Ages 2-18) Postpartum Care Timeliness of Prenatal Care
▼	**F** HIV—Engaged in Care	**D** Well Care Visits-First 15 Months (5+ Visits)	**C** Frequency of Ongoing Prenatal Care

NYSDOH QUALITY INCENTIVE

The percentage of the potential financial incentive that an MCO receives is based on quality of care, consumer satisfaction, and compliance. Points earned are derived from an algorithm that considers QARR 2016 (MY 2015) rates in comparison to statewide percentiles, the most recent Medicaid CAHPS® scores, and compliance information from MY 2013 and MY 2014. The total score, based out of 150 possible points, determines what percentage of the available premium increase the MCO qualifies for. For 2015, there were five tiers of incentive awards that could be achieved by MCOs based on the results. **Table 16** displays the points the MCO earned from 2013 to 2015, as well as the percentage of the financial incentive that these points generated based on the previous measurement year's data. **Table 17** displays the measures that were used to calculate the 2015 incentive, as well as the points the MCO earned for each measure.

Table 16: Quality Incentive Points Earned—2013-2015

	2013		2014		2015	
	Hudson	Statewide Average	Hudson	Statewide Average	Hudson	Statewide Average
Total Points (150 Possible Points)	132.4	80.8	91	73.8	86.5	75.2
PQI Points *(20 Possible Points)*	10	6.9	15	6.9	12.5	6.9
Compliance Points *(-20 Possible Points)*	-4	-5.4	-2	-4	0	-3.6
Satisfaction Points *(30 Possible Points)*	60	15.9	25	16.3	20	20
Quality Points[1] *(100 Possible Points)*	96	63.4	53	54.5	54.0	56
Financial Incentive Award Designation[2]	100%		75%		Tier 2	

[1] Quality Points presented here are normalized.

[2] For Reporting Year 2015, the incentive award designation was changed from a percentile ranking to a tier ranking. The highest performing tier level is Tier 1, while the lowest performing tier level is Tier 5.

Table 17: Quality Incentive Measures and Points Earned—2015

Measure	MCO Points
PQI	**12.5**
Adult Composite PQI *(10 points)*	5.0
Pediatric Composite PDI *(10 points)*	7.5
Compliance	**0.0**
MMCOR	0.0
MEDS	0.0
QARR	0.0
Access/Availability	0.0
Provider Directory	0.0
Member Services	0.0
Satisfaction (10 points each)	**20.0**
Rating of Health Plan	5.0
Getting Care Needed	10.0
Customer Service	5.0
Quality (3.03 points each, except where noted)	**33.3**
Adult BMI Assessment	1.52
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	0.0
Antidepressant Medication Management	1.52
Annual Monitoring for Patients on Persistent Medications	0.0
Appropriate Testing for Pharyngitis	2.27
Avoidance of Antibiotics Therapy in Adults with Acute Bronchitis	0.0
Breast Cancer Screening	1.52
Cervical Cancer Screening	0.0
Chlamydia Screening	0.0
Childhood Immunization Status (Combo 3)	0.0
Colorectal Cancer Screening	0.0
Comprehensive Care for People Living with HIV/AIDS—Engaged in Care	0.0
Comprehensive Diabetes Care—Received All Tests	1.52
Comprehensive Diabetes Care—HbA1C Control < 8.0%	1.52
Controlling High Blood Pressure	0.0
Diabetes Monitoring for People with Diabetes and Schizophrenia	0.0
Flu Shot for Adults (CAHPS)	0.0
Follow Up After Hospitalization for Mental Illness Within 7 Days	0.0
Follow Up for Children Newly Prescribed ADHD Medication	1.52
Human Papillomavirus Vaccination for Female Adolescents	1.52
Immunizations for Adolescents	2.27
Medical Assistance with Tobacco Cessation (CAHPS)	0.0
Medication Management for People with Asthma (Ages 5-64)	0.0
Persistence of Beta-Blocker Treatment After a Heart Attack	2.27
Use of Imaging Studies for Low Back Pain	0.0
Use of Spirometry Testing in the Assessment and Diagnosis of COPD	0.0
Weight Assessment and Counseling for Children and Adolescents	2.7
Annual Dental Visit (Ages 2-18)	3.03
Frequency of Ongoing Prenatal Care (81% and more)	3.03
Timeliness of Prenatal Care	3.03
Postpartum Care	3.03
Well Child Visits in the First 15 Months—Five or more visits	1.52
Well Child Visits in the 3rd, 4th, 5th and 6th Year	0.0
Total Normalized Quality Points[1]	**54.0**
Total Points Earned	**86.5**

MMCOR: Medicaid Managed Care Operating Report

MEDS: Medicaid Encounter Data Set

[1] Quality Points were normalized before being added to the total points earned. The points each MCO earned for each quality measure were aggregated and converted to normalized quality points. Quality points were normalized in order to control for a difference in base points, as not every MCO could earn points for each measure due to small sample sizes (less than 30 members).

PERFORMANCE IMPROVEMENT PROJECT

Each MCO is required by the Medicaid Health Maintenance Organization contract to conduct at least one Performance Improvement Project (PIP) each year. A PIP is a methodology for facilitating MCO- and provider-based improvement in quality of care. PIPs place emphasis on evaluating the success of interventions to improve quality of care. Through these projects, MCOs and providers determine what processes need to be improved and how they should improve.

The NYS EQRO provided technical assistance to MCOs throughout the PIP process in the following forms: 1) review of the MCO's Project Proposal prior to the start of the PIP; 2) quarterly teleconferences with the MCO for progress updates and problem-solving; 3) feedback on methodology, data collection tools, and implementation of interventions; and 4) feedback on drafts of the MCO's final report.

In addition, the NYS EQRO validated the MCO's PIP by reviewing the project topic, aim statement, performance indicators, study population, sampling methods (if sampling was used), data collection procedures, data analysis, and interpretation of project results, as well as assessing the MCO's improvement strategies, the likelihood that the reported improvement is "real" improvement, and whether the MCO is likely to be able to sustain its documented improvement. Validation teams met quarterly to review any issues that could potentially impact the credibility of PIP results, thus ensuring consistency among validation teams. The validation process concluded with a summary of the strengths and opportunities for improvement in the conduct of the PIP, including any validation findings that indicated the credibility of the PIP results was at risk.

Hudson's 2015-2016 PIP topic is *"Improving Performance in Smoking Cessation for our Medicaid Members"*. During 2015, the MCO implemented the following interventions:

- Members identified from claims data as smokes will be sent a letter explain the MCO's cessation program and reminding them to discuss counseling and treatments with PCPs. The letter will include the NYS Refer-to-Quit form, which the member will be asked to complete and return. The forms will be forwarded to providers to ensure providers receive status reports on members from the NYS QuitLine.
- Health Practices newsletters containing an article about Tobacco Cessation Counseling to mailed to providers. CRCs and the Program Manager will carry the newsletter with them to emphasize the program to providers. They will also talk to 432 Medicaid primary care offices to educate them on the importance of smoking cessation, emphasize clinical support, and review billing codes.
- Email and fax Medicaid offices and providers to alert them of the PIP and to ask for assistance in counseling members.
- Distribute waiting room tear-off pads to PCPs with member-friendly information.
- Living Well Newsletter with an article about Tobacco Cessation Program and the NYS Smokers QuitLine mailed to members.
- Members will receive calls from a QuitLine Coach who will provider tailored coaching cessation sessions.
- The MCO will receive progress reports from the QuitLine that will provide information on referred members call outcomes, quit status, NRT eligibility, and status on a biweekly basis.

Table 18 presents a summary of Hudson's 2015-2016 PIP.

Table 18: Performance Improvement Project—2015-2016
Results not shown, as 2015 was the first phase of the MCO's two-year PIP. Results will be included in the 2016 EQRO Technical Report.

HEALTH DISPARITIES

For this year's technical report, the NYS EQRO evaluated MCOs with respect to their activities to identify and/or address gaps in health outcomes and/or health care among their Medicaid population according to at-risk characteristics such as race, ethnicity, gender, geography, etc. This information was obtained through surveying MCOs regarding the following activities:

1. Characterization, identification, or analysis of the MCO's Medicaid population according to at-risk characteristics.
2. Identification of differences in health outcomes or health status that represent measurable gaps between the MCO's Medicaid population and other types of health care consumers.
3. Identification of gaps in quality of care for the MCO's Medicaid members and/or Medicaid subgroups.
4. Identification of determinants of gaps in health outcomes, health status, or quality of care for at-risk populations.
5. Development and/or implementation of interventions that aim to reduce or eliminate differences in health outcomes or health status and to improve the quality of care for MCO members with at-risk characteristics.

Hudson did not report any activities that were performed in 2015 to identify and/or address disparities in health outcomes and/or health care among its Medicaid population.

VI. Health Information Technology

According to the US Department of Health & Human Services, health information technology (HIT) allows comprehensive management of medical information and its secure exchange between health care consumers and providers. Broad use of HIT will improve health care quality, prevent medical errors, reduce health care costs, increase administrative efficiencies, decrease paperwork, and expand access to affordable health care.

In 2015, the NYS EQRO surveyed Medicaid MCOs regarding the use of HIT to improve the care of its Medicaid members. Specifically, MCOs were asked to report on:

1. Secure electronic transfer of Health Insurance Portability and Accountability Act (HIPAA) protected information to patients and/or providers and support staff
2. Use of telecommunications technologies
3. Use of Electronic Health Records (EHR)
4. Use of electronic internal registries
5. Use of clinical risk group (CRG) or similar software
6. Secure electronic transfer of member data between the MCO, its vendors, and network providers
7. Electronic communication with providers
8. Electronic communication with members
9. Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)[1]
10. Participation in State, Federal, or privately funded HIT initiatives
11. Participation in a medical home pilot or program
12. Future plans to implement HIT

Table 19 displays the statewide results of the HIT survey. Of the fifteen MCOs who responded to the survey, 100% utilized secure electronic transfer of member data between the MCO, its vendors, and/or network providers. Additionally, 100% of MCOs utilized electronic communication with providers and secure electronic transfer of PHI to patients and/or providers. Some of the other forms of HIT utilized by the majority of MCOs (93%) include telecommunications technologies, Electronic Health Records (EHR), and use of clinical risk group (CRG) or similar software. In addition, 93% of MCOs reported future plans to implement HIT.

[1] Regional Health Information Organizations/Health Information Exchanges are organizations that exist to enable interoperable health information exchange through governance and collaboration with an overall mission to improve health care quality and safety, and reduce costs.

Table 19: MCO Use of Health Information Technology—2015 Survey of NYS MCOs

Health Information Technology	% of MCOs Reporting Use
Secure electronic transfer of member data between the Plan, its vendors and/or network providers	100%
Electronic communication with providers	100%
Secure electronic transfer of protected health information to patients and/or providers	100%
Future plans to implement HIT	93%
Use of clinical risk group (CRG) or similar software	93%
Use of telecommunications technologies	93%
Use of Electronic Health Records (EHR)	93%
Electronic communication with members	53%
Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)	53%
Participation in a medical home pilot or program	47%
Use of electronic internal registries	47%
Participation in State, Federal or privately funded HIT initiatives	27%

Hudson has indicated that it performs the following HIT-related activities:

- Secure electronic transfer of protected health information to patients and/or providers
  - Use of SFTP and e-mail using Zix

- Use of telecommunications technologies
  - Use of telecommunication technologies to provide call center services

- Use of Electronic Health Records (EHR)
  - Access to a number of EHR integrated into gaps in care reports and distribute back to the appropriate providers for intervention

- Use of electronic internal registries
  - Registry for non-AHT (Adjunct Hormone therapy) compliant enrollees
  - Clinical Information Database
  - Disease Management Hierarchy

- Use of clinical risk group (CRG) or similar software
  - Yes

- Secure electronic transfer of member data between the Plan, its vendors and/or network providers
  - Via SFTP w/ PGP encryption

- Electronic communication with providers
  - Via SFTP with PGP encryption or Zix e-mail encryption

- Electronic communication with members
  - Via Zix e-mail encryption

- Participation in a Regional Health Information Organization (RHIO) or Health Information Exchange (HIE)
  - Associated with Rochester RHIO and HIXNY

- Participation in any State, Federal or privately funded initiatives
  - PSYCKES, ePACES, HIXNY, HCS, and Rochester RHIO

- Participation in a medical home pilot or program
  - Adirondack PCMH
  - Shared claims data with an aggregator that configured an all-payer database to assess the quality and efficiency of participant practices and guide their improvement initiatives

- Future plans to implement HIT
  - Will be implementing an automated analytics solution and eliminate ad hoc report requests to the MVP Informatics team by making data available on demand to enable internal end users in real time.

VII. Deficiencies and Appeals

COMPLIANCE WITH NYS STRUCTURE AND OPERATION STANDARDS

This section of the report examines deficiencies identified by the NYSDOH in operational and focused surveys, as well as external appeals, as part of the EQRO's evaluation of the MCO's compliance with State structure and operation standards.

Compliance with NYS Structure and Operation Standards

To assess the compliance of an MCO with Article 44 of the Public Health Law and Part 98 of the New York Code of Rules and Regulations (NYCRR), the NYSDOH conducts a full monitoring review of the MCO's compliance with structure and operation standards once every two years. These standards are reflected in the 14 categories in **Table 21**. "Deficiencies" represent a failure to comply with these standards. Each deficiency can result in multiple "citations" to reflect each standard with which the MCO is not in compliance.

The full monitoring review consists of an operational survey. The on-site component includes review of the following: policy and procedures, executed contracts and credentialing files of randomly selected providers, adverse determination utilization review files, complaints and grievances files, meeting minutes, and other documentation. Staff interviews are also conducted. These reviews are conducted using two standardized tools, the "Medicaid Managed Care Contract Surveillance Tool" and the "Review Tool and Protocol for MCO Operational Surveys". The NYSDOH retains the option to deem compliance with standards for credentialing/ recredentialing, quality assurance/improvement, and medical record review.

The Monitoring Review Report documents any data obtained and deficiencies cited in the survey tools. Any statements of deficiencies (SODs) are submitted to the MCO after the monitoring review, and the MCO is required to respond with a plan of corrective action (POC). POCs must be submitted to the NYSDOH for acceptance. In some cases, revisions may be necessary and MCOs are required to resubmit. Ultimately, all MCOs with SODs must have a POC that is accepted by the NYSDOH. During the alternate years when the full review is not conducted, the NYSDOH reviews any modified documentation and follows up with the MCO to ensure that all deficiencies or issues from the operational survey have been remedied.

In addition to the full operational survey conducted every two years, the NYSDOH also conducts several focused reviews as part of the monitoring of structure and operation standards. The focused review types are summarized in **Table 20**. MCOs are also required to submit POCs in response to deficiencies identified in any of these reviews.

Table 21 reflects the total number of citations for the most current operational survey of the MCO, which ended in 2015, as well as from the focused reviews conducted in 2015. This table reflects the findings from reviews of the MCO as a whole and deficiencies are not differentiated by product line. It is important to note that the number of deficiencies and the number of citations may differ, since each deficiency can have multiple citations.

Hudson was fully compliant with all 14 categories. The MCO did not receive any citations.

Table 20: Focused Review Types

Review Name	Review Description
Access and Availability	Provider telephone survey of all MMC plans performed by the NYSDOH EQRO to examine appointment availability for routine and urgent visits; re-audits are performed when results are below 75%.
Complaints	Investigations of complaints that result in an SOD being issued to the plan.
Contracts	Citations reflecting non-compliance with requirements regarding the implementation, termination, or non-renewal of MCO provider and management agreements.
Disciplined/Sanctioned Providers	Survey of HCS to ensure providers that have been identified as having their licenses revoked or surrendered, or otherwise sanctioned, are not listed as participating with the MCO.
MEDS (Medicaid Encounter Data Set)	Citations reflecting non-compliance with requirements to report MCO encounter data to the Department of Health.
Member Services Phone Calls	Telephone calls are placed to Member Services by AO staff to determine telephone accessibility and to ensure correct information is being provided to callers.
Other	Used for issues that do not correspond with the available focused review types.
Provider Directory Information	Provider directories are reviewed to ensure that they contain the required information.
Provider Information – Web	Review of MCO's web-based provider directory to assess accuracy and required content.
Provider Network	Quarterly review of HCS network submissions for adequacy, accessibility, and correct listing of primary, specialty, and ancillary providers for enrolled population.
Provider Participation – Directory	Telephone calls are made to a sample of providers included in the provider directory to determine if they are participating, if panels are open, and if they are taking new Medicaid patients. At times, this survey may be limited to one type of provider.
QARR (Quality Assurance Reporting Requirements)	Citations reflecting non-compliance with requirements to submit MCO QARR data to the Department of Health.
Ratio of PCPs to Medicaid Clients	Telephone calls are placed to PCPs with a panel size of 1,500 or more Medicaid clients. The calls are used to determine if appointment availability standards are met for routine, non-urgent "sick", and urgent appointments.

AO: Area Office
HCS: Health Commerce System
SOD: Statement of Deficiency

Table 21: Summary of Citations

Category	Review Type/Name (✔ indicates focused review)		Citations
Complaints and Grievances			0
Credentialing			0
Disclosure			0
Family Planning			0
HIV			0
Management Information Systems			0
Medicaid Contract			0
Medical Records			0
Member Services			0
Organization and Management			0
Prenatal Care			0
Quality Assurance			0
Service Delivery Network			0
Utilization Review			0
TOTAL			**0**

Note: Hudson Health Plan, Inc. withdrew from the Medicaid program and transferred its Medicaid Membership to MVP, effective January 1, 2016. Hudson's COA was revised to limit operations to "payment of remaining liabilities and other close out activities".

EXTERNAL APPEALS

Table 22 displays external appeals for 2013 to 2015 for the Medicaid and CHP product lines. This table reflects absolute numbers, and is not weighted by MCO enrollment.

Table 22: External Appeals—2013-2015

	2013	2014	2015
		Medicaid	
Overturned	18	24	25
Overturned in Part	1	4	10
Upheld	36	26	44
Medicaid Total	**55**	**54**	**79**
		CHP	
Overturned	1	1	1
Overturned in Part	0	0	0
Upheld	3	0	1
CHP Total	**4**	**1**	**2**

VIII. Financial Data

The financial summary is based on data reported in each MCO's 2014 and 2015 Medicaid Managed Care Operating Report (MMCOR). The data contained in the MMCOR reflect the MCO's Medicaid line of business only. The data are not audited and are reported on an accrual basis; thus, total expenses are impacted by an MCO's estimate of services that have been incurred by MCO members but have not been billed to the MCO. The following is a list of the ratios displayed in **Table 23** and their definitions:

- *Assets to Net Worth:* Reflects the relationship of assets to net worth. For example, an MCO with an asset to net worth ratio of 3.0 indicates the MCO has $3 of assets for every $1 of net worth. The formula is total assets divided by net worth. Assets and net worth are the net of intangible assets.
- *Premium Surplus Ratio:* Indicates what percentage of premium dollars goes towards surplus. This ratio is calculated by dividing premium income by total premium revenue. It indicates whether an MCO is generating sufficient revenue from its premiums to cover medical and administrative expenses.
- *Medical Loss Ratio:* Indicates what percentage of premium dollars is spent on medical costs. This ratio is calculated by dividing total medical costs by total premium revenue.
- *Administrative Ratio:* Indicates what percentage of premium dollars is spent on administrative costs. This ratio is calculated by dividing total administrative costs by total premium revenue.
- *Current Ratio:* Reflects to what degree current assets cover current liabilities. The formula is current assets divided by current liabilities.

Table 23: Selected Financial Ratios—2014-2015

	2014		2015	
	Hudson	**SWA**	**Hudson**	**SWA**
Profitability				
Assets to Net Worth = (Total Assets-Intangibles)/ (Net Worth-Intangibles)	1.58	2.09	1.55	2.14
Premium Surplus Ratio = Premium Income/ Revenue Income	6.8%	-12.3%	7.0%	0.0%
Medical Loss Ratio = Medical Expenses/ Premium Revenue	89.2%	101.5%	87.2%	90.6%
Administrative Ratio = Admin. Expenses/ Premium Revenue	1.2%	7.3%	7.2%	10.0%
Liquidity				
Current Ratio = Current Assets/Current Liabilities	2.7	2.1	3.1	2.1

Figure 4a: Assets to Net Worth and Current Ratio

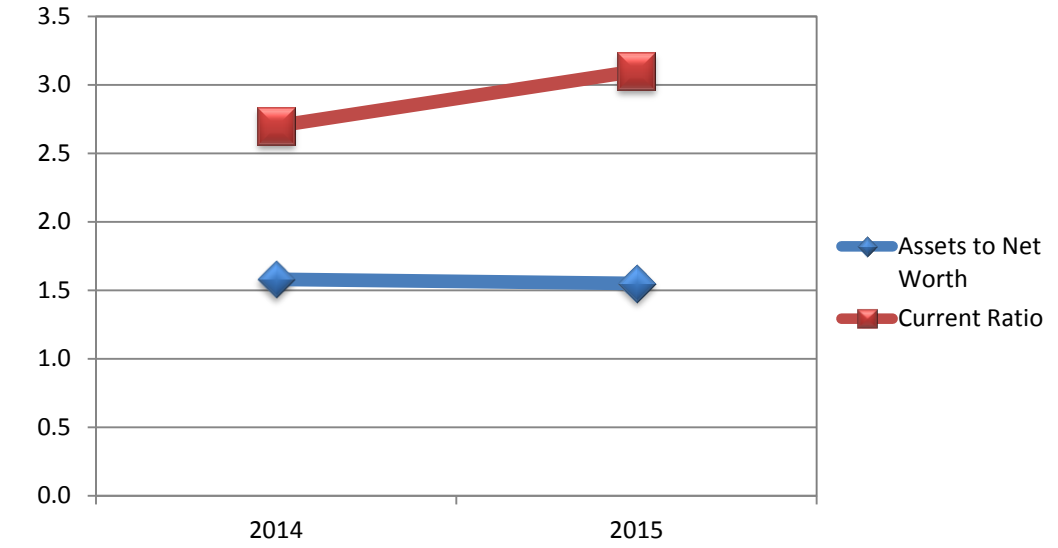
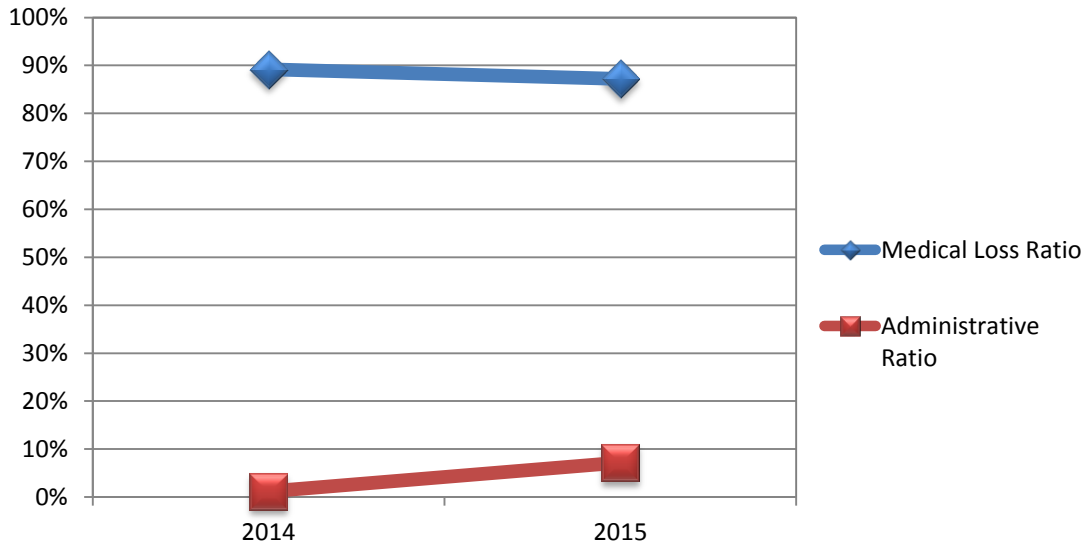


Figure 4b: Medical Loss Ratio and Administrative Ratio



IX. Strengths and Opportunities for Improvement[2]

This section summarizes the accessibility, timeliness, and quality of services provided by the MCO to Medicaid and Child Health Plus recipients based on data presented in the previous sections of this report. The MCO's strengths in each of these areas are noted, as well as opportunities for improvement. Recommendations for enhancing the quality of health care are also provided based on the opportunities for improvement noted. An assessment of the degree to which the MCO has effectively addressed the recommendations for quality improvement made by the NYS EQRO in the previous year's EQR report is also included in this section. The MCO's response to the previous year's recommendations, wherein the MCO was given the opportunity to describe current and proposed interventions that address areas of concern, as well as an opportunity to explain areas that the MCO did not feel were within its ability to improve, is appended to this section of the report.

Strengths

- The 2016 HEDIS® 2016 Final Audit Report revealed no significant issues and the MCO was able to report all required QARR measures.
- Hudson earned PQI, compliance, satisfaction, and quality points to qualify the MCO for the Tier 4 financial incentive award designation.
- The MCO's rates were reported above the statewide average for the HEDIS®/QARR *Board Certification* measure for Pediatricians and Other Physician Specialists.
- In regard to overall HEDIS®/QARR performance, the MCO has reported an above average rate for at least three consecutive reporting years for the *Annual Dental Visits (Ages 2-18)* measure. Additionally, the MCO's rates were above average for the following measures: *Adolescents—Alcohol and Other Drug Use, Adolescents—Depression, Adolescents—Tobacco Use, Asthma Medication Ratio (Ages 5-18), Diabetes BP Controlled (<140/90 mm Hg), Children—BMI Percentile, Children—Counseling for Nutrition,* and *Children—Counseling for Physical Activity.*
- The MCO performed well in regard to member satisfaction. Rates were reported above the statewide average for the following CAHPS® measures: *Getting Care Needed, Satisfaction with Provider Communication, Rating of Health Plan—High Users, Rating of Specialist,* and *Recommend Plan to Family/Friends.*

Opportunities for Improvement

- The MCO continues to demonstrate an opportunity for improvement in regard to overall HEDIS®/QARR performance. The MCO has reported rates below the statewide average for at least three consecutive reporting years for the following measures: *Use of Imaging Studies for Low Back Pain, Medical Management for People with Asthma 50% of Days Covered (Ages 19-64), Medical Management for People with Asthma 50% of Days Covered (Ages 5-18),* and *Spirometry Testing for COPD*. Additional measures for which the MCO reported below average rates include *Flu Shots for Adults (Ages 18-64), Chlamydia Screening (Ages 16-24), Colon Cancer Screening, HIV—Engaged in Care, HIV—Syphilis Screening, Annual Monitoring for Patients on Persistent Medications—Combined Rate, Well-Child Visits—3 to 6 Year Olds,* and *Well-Care Visits for Adolescents.* (Note: *Use of Imaging Studies for Low Back Pain, Chlamydia Screening (Ages 16-24), Medical Management for People with Asthma 50% of Days Covered (Ages 19-64), Medical Management for People with Asthma 50% of Days Covered (Ages 5-18), Annual Monitoring for Patients on Persistent Medications—Combined Rate, Spirometry Testing for*

[2] This section of the report emphasizes the maintenance of current good practices and the development of additional practices resulting in improved processes and outcomes, and thus refers to "Strengths" and "Opportunities for Improvement" rather than "Strengths" and "Weaknesses" as indicated in federal regulations.

COPD, Well-Child Visits—3 to 6 Year Olds, and *Well-Care Visits for Adolescents* were opportunities for improvement in the previous year's report.)

- The MCO continues to demonstrate an opportunity for improvement in regard to access to primary care. The MCO reported rates below the 10th percentile for the *Children and Adolescents' Access to PCPs* measure for the following age groups: 25 Months-6 Years, 7-11 Years, and 12-19 Years. (Note: access to primary care was an opportunity for improvement in the previous year's report.)

Recommendations

- The MCO should continue to work to improve the HEDIS®/QARR measures that consistently perform below average. As several of the measures are related to respiratory conditions and preventive care, the MCO should conduct a thorough barrier analysis to identify barriers its members face when attempting to access care or pharmacies. *[Repeat recommendation.]*

Response to Previous Year's Recommendations

Note: MVP and Hudson Health Plan completed their merger effective 1/1/2016. However, the quality programs began integrating in 2014, and were fully integrated for most of 2015. Our response will address the specific findings related to each plan individually, and then provide a summary of common actions taken related to the quality measures and programs.

MVP Health Care

- **2014 Recommendation:** In order to ensure members have adequate access to primary care, the MCO should work with its provider network to meet the established 75% compliance rate for the Primary Care Access and Availability Survey.

  MCO Response: MVP, through its merger with Hudson Health Plan, has expanded its Medicaid network of providers. We are working with the network to assure access and availability in compliance with the standards. Provider Relations (PR) Representatives address access and availability issues with providers in each region. In 2017, PR Representatives have a goal to meet with PCPs and OB/GYNs two times per year to review and verify provider adherence to the access and availability standards. All practices will get a laminated access and availability standards sheet as a point of reference.

  PR will also conduct "secret shopper" calls to practices to assess their readiness, and if necessary, further attention will be given to practices that perform below access and availability standards. All visits to practices, outreach to confirm participation and verify access and availability standards, and secret shopper calls will be documented, tracked, and are part of the PR Representative's personal goals for 2017. Results of PRs' visits will continue to be reported to the MVP Corporate Compliance Committee on a quarterly basis for oversight. We expect the overall primary care access and availability scores to show improvement in 2017 as a result of these efforts.

- **2014 Recommendation:** The MCO should continue to work to address issues noted in the Article 44 and focused review surveys. *[Repeat recommendation.]*

  MCO Response: On August 7, 2014, the NYS Department of Health (DOH) reported its Statement of Findings to MVP and requested a plan of correction. MVP responded with a commitment to updating specific policies and procedures related to ID Cards, Utilization Management, and Appeals turnaround timeframes and compliant clinical rationales, and oversight of delegated entity-specific templates, policies, and procedures. The plan of correction was accepted by DOH on November 12, 2014, and MVP continued to implement and audit the actions identified in the plan of correction into 2015. In June

2015, MVP Health Plan underwent a comprehensive survey with the DOH. All findings note were addressed in a plan of correction and accepted by the DOH. A targeted survey in November 2016 demonstrated full compliance with the plan of correction. MVP has and will continue internal monitoring and delegation oversight through metrics reports, policy and procedure review, files audits, where applicable, and at least annual audits of each delegate.

Hudson Health Plan

- **2014 Recommendation:** The MCO should continue to work to address the issues noted in the focused reviews. As the citations the MCO received relate to provider directory information, the MCO should modify its strategy to improve the accuracy of provider network data. *[Repeat recommendation.]*

  MCO Response: MVP strives to provide the most up-to-date information to our members through the provider directory. To increase provider data accuracy, MVP developed a validation process for all addresses and sites to the individual provider level during the recredentialing process that was implemented in 2016. This process will continue as a permanent part of recredentialing. In addition, increased monitoring and assessment of internal data management processes including routine quality checks on all provider demographic data, an annual program effectiveness review specifically related to provider data, and a quality oversight process that includes calls to a random sample of provider offices to confirm demographic information across all regions has been implemented to improve the accuracy of provider network data.

  In March 2016, a quarterly notification process was implemented to confirm that the provider demographic information in the online directory is accurate for each provider. Providers are required to review their demographic information in the MCP directory, and notify MVP of any inaccuracies in order for the directory to be updated. If demographic information is identified as incorrect, providers are directed to use the MVP change form to submit the correct information to MVP via fax.

  Also in 2016, MVP began distribution of current provider rosters during all practice Provider Relations routine visits to confirm they were accurate and capture any changes. Verification of all provider demographics and network participation status was conducted during these visits and will increase frequency of validation visits for Primary Care Physicians and OB/GYNs throughout 2017.

MVP Health Care (combined with Hudson Health Plan)

- **2014 Recommendation:** The MCO should continue to evaluate and update its HEDIS®/QARR quality improvement strategies discussed in the response to the previous year's recommendation. Additionally, as Hudson Health Plan and MVP Health Plan have integrated their quality improvement programs, the MCO should leverage that relationship to identify and implement best practices for quality improvement. *[Repeat recommendation.]*

  MCO Response: MVP has engaged in a series of activities to address deficiencies in HEDIS®/QARR performance:
  - MVP is revising all provider gaps-in-care reports to easily identify their care gaps for HEDIS®/QARR measures, including any variance from 90th and 75th percentile.
  - MVP created a new management position that is dedicated to implementation and oversight of quality improvement activities that impact HEDIS®/QARR performance. MVP is also adding new resource groups to support provider practices through strategy development and improved report distribution.

- *Member Incentive Program*—MVP members continued to receive monetary incentives in the form of gift cards for seeking relevant preventive and/or treatment-based care for specific quality measures. Mailings inform members of the incentive program, and encourage those who have not achieved compliance. Non-compliant members are contacted by mail and/or telephone to inform them of the importance of the services and to assist in addressing barriers to compliance. Data is collected on the response to the incentives to determine which are effective for future adjustments.
- *Provider Incentive Program*—MVP providers continued to receive monetary incentives for delivering preventive or treatment-based care to at-risk members. MVP also provided aggregate level provider-specific reporting for select quality measures and met with providers to assist them with understanding and responding to their specific areas of opportunity. The Provider Incentive program is linked to the member incentives to improve compliance.
- *Data Quality Validation (DQV)* process was initially introduced by Hudson Health Plan and later adopted by MVP. We are now enhancing the process through provision of additional data in a format that is more readily automated. Data will be provided to individual groups as well as used internally for targeting activities. The DQV tools previously developed are still available for use as well. Implementing a previous process used by Hudson Health Plan.

All of the aforementioned incentive activities were continuous, fully-implemented, and mature interventions for RY 2015. Most continued into or were enhanced for RY 2016. Expected outcomes for these interventions are generally to maintain or improve the performance of MVP quality measures and support increased member satisfaction with the plan.

MVP performed annual program evaluations for the incentive and gaps-in-care interventions to monitor ongoing effectiveness. Evaluations focused on statistical analysis to correlate interventions with potential changes to measure performance. Interventions may be discontinued or changed as a result of these ongoing evaluations.

X. Appendix

REFERENCES

A. Corporate Profile

- Updated Corporate Profile information provided by the NYSDOH
- NYSDOH OMC DataLink Reports
  - Managed Care Plan Directory
- NCQA Accreditation website, http://hprc.ncqa.org/index.asp

B. Enrollment/Provider Network

1. *Enrollment/Disenrollment*
   - NYSDOH OMC Membership Data, 2013-2015
   - Enrollment by Age and Sex Report as of December 2015
   - Enrollment Status by Aid Category and County as of December 2015
   - Auto Assignment Data, 2013-2015
   - Auto Assignment Quality Algorithm Scores, 2013-2015
   - Enrollment Status Report, 2015
2. *Provider Network*
   - Providers Statewide by Specialty, Medicaid Managed Care in New York State Provider Network File Summary, December 2015
   - Total Number of FTEs by Managed Care Plans, December 31, 2015
   - NYSDOH OMC Primary Care Providers Open and Closed Panels by Plans, Provider Network Data as of December 31, 2015
   - QARR Measurement Year, 2013-2015

C. Utilization

1. *Encounter Data*
   - MMC Encounter Data System, 2013-2015
2. *QARR Use of Services*
   - QARR Measurement Year, 2013-2015

D. Quality Indicators

1. *Summary of HEDIS® Information Systems Audit™ Findings*
   - 2016 Final Audit Report prepared by the MCO's Certified HEDIS® Auditors
2. *QARR Data*
   - Performance Category Analysis, Quality Performance Matrix (2015 Measurement Year)
   - QARR Measurement Year, 2013-2015
3. *CAHPS® 2015 Data*
   - QARR Measurement Year, 2015
4. *Quality/Satisfaction Points and Incentive*
   - Quality/Satisfaction Points and Incentive, 2013-2015
5. *Performance Improvement Project*
   - 2015-2016 PIP Report
6. *Health Disparities*
   - NYSDOH Health Disparities Survey, 2015

E. Health Information Technology

- NYSDOH Health Information Technology Survey, 2015

F. Deficiencies and Appeals

1. *Summary of Deficiencies*
   - MMC Operational Deficiencies by Plan/Category, 2015
   - Focus Deficiencies by Plan/Survey Type/Category, 2015
2. *Appeals*
   - MMC External Appeals Data, 2015

G. Financial Data

- Medicaid Managed Care Operations Report, 2015